REPUBLIC OF GHANA

What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

NAVRONGO HEALTH RESEARCH CENTRE

Vol. 4, No. 6 Navrongo Health Research Centre

THE RIGHT ROAD TO BAMAKO

Although many countries in sub-Saharan Africa have different cultures, delivery of national family planning (FP) programmes is relatively uniform: clinical services are developed for referral services and the provision of long-acting contraception; community-based distribution (CBD) is developed for non-clinical methods. It is widely assumed that making FP services available in community locations will inevitably lead to increased use of contraception and reduced fertility. To this day, the Community Health and Family Planning Project (CHFP) of the Navrongo Health Research Centre (NHRC) tests the relative effectiveness of alternative strategies for achieving increased contraceptive use and low fertility. In keeping with the spirit of Health for All, facilities, staff, and medical supplies utilised in the experiment are resources routinely available throughout the region and all study areas of the Kassena-Nankana District have the same density of health care providers per population, the same level of training, and the same medical supplies. Thus, the CHFP experiment tests whether these alternative strategies for utilising these resources at the community level are effective.

Though paved with good intentions the road to Bamako is full of twists and turns

The *zurugelu* intervention involves mobilizing traditional social institutions in health delivery and planning, as called for by the UNICEF-sponsored "Bamako Initiative", which promotes the idea that managing health care resources and providing revolving funds for primary health care drugs and services through community volunteers can be a sustainable means of achieving Health for All. Village health committees, termed *Yezura Nakwa* (YN), were established in collaboration with chiefs, elders, and other community opinion leaders. The YN oversees a cadre of health volunteers named *Yezura Zenna* (YZ), who form the backbone of the *zurugelu* approach. The YZ main task is to sell the CHFP idea to the community, particularly men who exert considerable influence over women's' mobility to seek health care. YZ receive two weeks of initial training and quarterly refresher training. They visit households to talk about hygiene, child immunization, and other health issues, and to make it known that they are available for basic treatment and referrals. They have significant health resources at their disposal, including Paracetamol for febrile illnesses, Chloroquine for malaria, Aludrox for abdominal pains, and multivitamins, but they do not have antibiotics or vaccines. Instead, they provide referrals to the clinics and help organize immunization campaigns. Another important element of the *zurugelu* intervention is the *durbar*, or community gathering, which is traditionally used by chiefs to mobilize community action on some issue of common concern. *Durbars* provide an effective means of communicating project messages to communities, establish the integrity of the project, and build community support.

A health service mobilisation intervention tests the effectiveness of improving access to Community Health Officers (CHO) by reassigning them from sub-district clinics to community-constructed residences, known as Community Health Compounds (CHC), and equipping them to conduct door-to-door health services. CHO are trained for two years, paid a monthly salary, and provide a wider range of health intervention options than YZ.

In the combined intervention area, the *zurugelu* and CHO approaches are pursued simultaneously. This intervention tests the premise that the *zurugelu* and MOH mobilization interventions are complementary and synergistic, combining the implicit accountability and sustainability of the former with the relative advantages of professionalism in the latter. In the combined treatment area, close collaborative links have been established between the YZ and the CHO.

A study which dealt with the observation that CBD has not been subjected to a careful experimental trial has been carried out in the Kassena-Nankana District of northern Ghana. The study examined the net impact of training and deploying YZ to distribute the pill on overall contraceptive practice and choice of contraceptive method. A total of 14,234 women (individual women or women interviewed more than once) ages 15–49 from 1993 and 1995–2000 Navrongo Panel Surveys were included in the various statistical analyses which accounted for age composition,

educational attainment, and other background information. Several issues were analysed such as comparison of current contraceptive method use between the survey years and the determinants of current use of a contraceptive method by type of method. For the purposes of the study, the impact of CBD was considered to be defined by the incremental effect of YZ service delivery in the YZ areas versus YZ without pill CBD. In the combined areas, the impact of CBD was measured in terms of adding pill distribution to the community regimen that already involves CHO service delivery activities. In short, the findings are as follows:

- Unadjusted 1997 baseline prevalence rates for pill and other modern contraceptive use were the same in CBD and non-CBD areas of YZ and combined areas. Prior to intervention, pill use prevalence was uniformly low in both areas, comprising 1.3% of all women in non-CBD areas and in communities where CBD was subsequently introduced. Slight changes are suggested by the increase to 1.5% in distribution areas, while pill prevalence declined slightly in non-CBD areas.
- CBD exposure appears to have also impacted current use of modern methods other than oral contraceptive pills. Prior to intervention, use of other modern methods was 7.9% among women in YZ and combined cells, regardless of whether or not they were in an area assigned to receive subsequent CBD services. In 2000, prevalence of other modern methods dropped to 6.3% in areas where YZ distributed pills, and increased to 9.3% in areas with no CBD services.
- In the CHFP CHO and comparison areas, the prevalence of the use of pills and other modern methods changed very little between 1997 and 2000 within each cell. In CHO-only, the prevalence of pill use was 0.7% in 1997 and 0.8% in 2000, while pill use declined from 0.5% to 0.4% among women in the comparison area.
- Use of other modern methods also remained constant within each of these areas. In all experimental areas, use of methods to delay or avoid pregnancy not classified as modern (withdrawal, rhythm, or other traditional methods) declined from 1997 to 2000.

A re-examination of these relationships with a statistical method of analysis that assesses the significance of the conceived effect of CBD within the agenda of the CHFP experiment was conducted. This analysis assessed the chances of using a pill, other modern method, and non-modern methods (withdrawal, rhythm, or other traditional methods), relative to not using any method, among women exposed to CBD services while taking into account the duration of exposure to CHFP experimental treatment. The results show that there is an unexpected net *negative* effect of CBD on pill use and other method use. The chances of pill use are reduced by 33%; the chances of other modern methods of contraceptive use are diminished by 23% per year of exposure. This suggests that pill CBD in this context has significantly reduced the efficacy of the CHFP, most prominently the method that the intervention was designed to promote. This inconsistent effect cannot be explained by background characteristics and reproductive motives of respondents in the statistical analysis, or bias associated with the geographic distribution of the initiative.

In general, results from this study show that the effectiveness of the Navrongo combined service strategy is diminished by volunteer CBD. This may arise when CBD makes contraception convenient, while constraining choice to pills and condoms. Where CHO outreach is combined with male community mobilization, without associated CBD, virtually all adoption and use is injectable and NORPLANT® based. Findings suggest that resolving perceived social costs of FP may be more important to fostering the adoption and use of contraception than improving geographic accessibility. If convenient service providers are offering constrained contraceptive options, CBD can actually diminish overall programme impact by diverting choice to methods that are associated with low acceptability and continuity. Where demand for FP is emerging and fragile, the importance of developing socially appropriate service strategies is particularly acute.

Send questions or comments to: What works? What fails?
Navrongo Health Research Centre, Ministry of Health, Box 114, Navrongo, Upper East Region, Ghana
What_works?@navrongo.mimcom.net

This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programmes, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant of the Vanderbilt Family to the Population Council.